Coordination of HIV/AIDS, Substance Abuse and Mental Health Services for African American and Latina Women

A POLICY RESEARCH PROJECT

Report and Recommendations

Prepared by:

Miguelina León
Director of Government Relations and Public Policy
National Minority AIDS Council

Sponsored by:

✓Substance Abuse and Mental Health Services Administration (SAMHSA)
In Collaboration with
National Minority AIDS Council (NMAC)

NATIONAL MINORITY AIDS COUNCIL

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I. Executive Summary

As of December 31, 1999, a total of 733,374 cumulative AIDS cases had been reported to the Centers for Disease Control and Prevention (CDC). Of these cases, 82.5 percent were men, 16.3 percent were women and 1.2 percent were children less than 13 years of age. Approximately 43 percent were white, 37 percent were African American, 18 percent Hispanic/Latino/a, 0.72 percent Asian and Pacific Islander and 0.29 percent American Indian and Alaska Native.

Women of color have been disproportionately impacted by HIV/AIDS. Although they comprise one-fourth of the female population in the United States, they accounted for 82 percent of the new AIDS cases and 78 percent of the cumulative AIDS cases reported among women in 1999. Most severely impacted were African American and Latina women, who accounted for 63 percent and 18 percent, respectively, of the female AIDS cases reported during the 12 months ending December 31, 1999. Of the 10,780 cases reported among women, 27 percent were attributable to injecting drug use and 11 percent were due to heterosexual contact with an injecting drug user.

In November 1998, the Substance Abuse and Mental Health Services Administration (SAMHSA), through an interagency agreement with CDC, funded the National Minority AIDS Council (NMAC) to carry out a policy research project. The project was designed to assess the barriers to coordination and integration of substance abuse, mental health and HIV/AIDS services for African American and Latina women and to devise strategies for their integration. Two meetings were held during 1999 to carry out this project. A Policy Forum was held in Baltimore, Md., in April 1999, and a Focus Group Session was conducted in June 1999 during the Second SAMHSA National Women's Conference in Los Angeles, Calif.

Participants at the Policy Forum reviewed recent data on women's programs, discussed barriers to service coordination/integration and developed recommendations for SAMHSA. The Los Angeles Focus Group served to validate information from the Baltimore meeting and provide further input. This report contains some of the most salient points of the discussions in Baltimore and Los Angeles, as well as action steps for SAMHSA to develop activities to address the barriers to service coordination and integration.

A. Populations

During the Policy Forum, participants identified the following sub-populations of women as those in need of greater focus, due to their high risk for HIV and their lack of access to substance abuse, mental health and HIV-related services:

- Women Over 50 Years of Age
- Substance Abusers
- Transient Populations and Rural Women (immigrant, migrant, homeless)
- Incarcerated Women
- Women with High Risk Partners
- Adolescents
- Women with Children

B. Barriers

Women face a host of barriers to accessing health care. These barriers increase their vulnerability to HIV and impair their health outcomes once they become infected. Among the factors that make women more vulnerable are: substance abuse, mental illness, domestic violence, family responsibilities, lack of health insurance, lack of stable employment and the recurrence of sexually transmitted diseases. Participants of the Policy Forum and the Focus Group outlined the following barriers that women face:

- **Lack of Access to Quality Medical Care:** African Americans and Latinos/as experience poorer health outcomes as compared to the majority group due to racial and ethnic disparities in health care.
- **Service Fragmentation:** HIV prevention and health care, substance abuse and mental health services are delivered within a fragmented health care system. Service fragmentation, as well as lack of transportation and need for childcare, create significant barriers to accessing treatment and care for African American and Latina women.
- **Lack of Cultural Competency, Cultural Sensitivity and Culturally Specific Services:** Many women of color receive services in settings that are not culturally sensitive and lack culturally competent staff. Women of color need to receive services within the context of their culture and life situations. All services must be culturally appropriate and the staff delivering the services must be culturally competent.
- **Lack of Confidentiality:** Fear of disclosure of their HIV status and ensuing consequences, including violence, stigma and discrimination, may serve to deter women of color from seeking services. In the case of immigrant women, an HIV positive diagnosis may lead to deportation. Women of color must be assured of confidentiality in order to feel comfortable enough to get tested for HIV infection and receive services.
- **Competing Priorities:** Women of color experience a myriad of competing needs and priorities including economic subsistence, employment, housing, transportation, family responsibilities, parenting and child-care, and care-giving for children, partners, spouses and parents. Many services needed by women of color do not address these competing priorities.
- **Racism and Discrimination:** African American and Latina women have experienced discrimination and have been marginalized when they seek health care. Women-focused HIV/AIDS, substance abuse and mental health services and the funding to support such services have not been consistently prioritized by policy makers.
- **Lack of Cross Training:** Providers of HIV/AIDS prevention, health care, substance abuse and mental health services do not have the necessary expertise in the various disciplines needed to adequately address the multiple and complex needs of women of color. Most providers are experts in one field and do not receive training to increase their knowledge and understanding of other disciplines.

C. Recommendations

The following are highlights of the recommendations proposed by the participants in the Policy Forum and Focus Group Sessions to address these barriers:

- **Cultural Competence:** Federal, state and local funding agencies should develop and disseminate guidelines for service providers to use to create and implement culturally competent programs and service delivery structures that respond to the social and cultural contexts of the women of color they serve.
- **Program Design:** SAMHSA must promote and ensure the implementation of client-centered and client-driven programs, so that providers can understand the clients they serve and develop services that respond to their clients' needs, values, beliefs and decision-making processes. Prevention, treatment and care programs must provide age-appropriate, family-focused services that address the needs of women of color of various backgrounds and age groups.
- **Interagency Collaboration:** Government agencies at the federal, state and local levels should promote interagency collaboration, information sharing and joint funding to develop and implement integrated substance abuse, mental health and HIV programs.
- **Participatory Planning:** Federal, state and local funding agencies should increase the participation of providers and consumers in the planning processes for priority setting and funding allocations for HIV/AIDS, substance abuse and mental health services.
- **Accountability:** Federal, state and local agencies and programs need to be more accountable regarding their program and funding activities. They should demonstrate how funding is being used to address the substance abuse, mental health and HIV/AIDS-related needs of women of color.

II. Introduction

In November 1998, the Substance Abuse and Mental Health Services Administration (SAMHSA), through an interagency agreement with the Centers for Disease Control and Prevention (CDC), funded the National Minority AIDS Council (NMAC) to carry out a policy research project at the national level. The purpose of the project was to enhance coordination and collaboration between HIV/AIDS, mental health and substance abuse services for African American and Latina women at risk of HIV or living with HIV/AIDS. This research project was designed to provide SAMHSA with input regarding the barriers to coordination and collaboration and recommendations on how to address these barriers. Information contained in this report was to be used in the development of an HIV Strategic Plan for SAMHSA.

The impetus for this project was provided in part by the Congressional Black Caucus' call in 1998 for the Secretary of the U.S. Department of Health and Human Services (HHS) to declare a "State of Emergency" related to HIV/AIDS among African Americans. The project was also motivated by the "Preventing Substance Abuse and HIV" National Leadership Forum, held in Tampa, Florida, in 1996. At the Tampa Forum, a group of more than 100 policy makers and service providers identified cross-cutting issues and themes. They made a series of recommendations for actions to be taken at state and local levels to strengthen HIV and substance abuse prevention and treatment services. The recommendations called for increased linkages among HIV prevention and care programs, substance abuse prevention and treatment and mental health services. Several recommendations addressed the need for greater integration at state and local levels in order to bring about significant improvements in the delivery and effectiveness of prevention, treatment and service programs for substance abusers.

III. Overview

A. HIV and AIDS in the United States

At the end of 1999, a total of 733,374 AIDS cases had been reported to CDC, of which 82.5 percent were men, 16.3 percent were women and 1.2 percent were children less than 13 years of age. Forty three percent were white, 37 percent were African American, 18 percent were Hispanic/Latino/a, .72 percent were Asian and Pacific Islander, and .29 percent were American Indian and Alaska Native. In terms of risk factors, 47 percent were men who have sex with men (MSM), 25 percent were injection drug users (IDUs), 10 percent were individuals infected heterosexually, and 2 percent were individuals infected through blood or blood products. During the 1990s, the HIV/AIDS epidemic shifted steadily toward a growing proportion of AIDS cases in African Americans and Latino/as. The trends during this period also reflected a shift toward an increasing proportion of AIDS cases among women and a decreasing proportion of the cases among MSM, although this group remains the largest single exposure group.[1]

African Americans and Latinos/as, have experienced markedly higher AIDS rates than whites, and have been disproportionately affected since the early years of the epidemic. African Americans have outnumbered whites, in absolute numbers, in new AIDS diagnoses and deaths since 1996 and in the number of persons living with AIDS since 1998. Throughout the 1990s, the proportion of women with AIDS increased steadily, reaching 23 percent in 1999. Moreover, the proportion of women infected heterosexually also increased. By 1994 the proportion of heterosexually acquired AIDS cases among women surpassed the proportion of cases acquired through injection drug use. Effective HIV/AIDS therapies became available in the mid 1990s. The effects of these therapies on decreases in new AIDS cases (incidence) and in AIDS deaths were noted as early as 1996.

AIDS prevalence has steadily increased year to year, as deaths have decreased. This trend is expected to continue as long as the number of persons with a new AIDS diagnosis exceeds the number of persons dying each year. Among the pediatric AIDS cases reported in 1999, 25 percent were due to transmission from an HIV-positive mother who injected drugs, and in 13 percent of the cases, the mother became infected from having sex with an injecting drug user. Eighty-eight percent of the cases reported among children in 1999 were due to perinatal transmission. Of these cases, 38 percent were directly or indirectly attributable to injecting drug use.[2]

1. Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report*, 1999:11(2): 5.
2. Ibid, p. 5, 24.

B. Women of Color and HIV/AIDS

The impact of AIDS among ethnic and racial minority groups in the United States is significantly greater than among the total population. Of new AIDS cases reported in 1999, 68 percent of the adult/adolescent cases and 87 percent of the pediatric AIDS cases were among ethnic and racial minority groups. Although women of color are about one-quarter of the female population in the United States, women of color made up 82 percent of the new AIDS cases and 78 percent of the cumulative AIDS cases reported among women in 1999. Most severely impacted are African American women and Latina women who accounted for 63 percent and 18 percent, respectively, of the female AIDS cases reported in the 12-month period ending December 31, 1999.

A growing proportion of women are becoming infected with HIV through their own drug-using behaviors or through sexual contact with an HIV-infected partner, including ones who are also drug abusers. Of the new AIDS cases reported among African American and Hispanic/Latina women in 1999, injection drug use accounted for 25 percent and 28 percent, respectively, of the cases among these two groups. Heterosexual transmission accounted for 38 percent of the cases among African American women and 47 percent of the cases among Latina women. While AIDS cases due to heterosexual transmission are increasing significantly among women of color, a closer look reveals that 24 percent of the cases among African American and 29 percent of the cases among Hispanic/Latina women were due to sex with an injecting drug user. Overall, sex with an injecting drug user accounted for 9 percent of the new AIDS cases reported among African American and 14 percent of those among Hispanic/Latina women in 1999.[3]

According to the CDC, between 120,000 and 160,000 women are estimated to be living with HIV disease in the United States and less than 50 percent know their sero-status or that of their partners. Many will not be tested until they seek prenatal care, they give birth, or they or their partners develop an AIDS-related illness. The health status of women with HIV compares poorly to that of men with HIV. Women are more likely to have higher viral loads and lower CD4 counts when they enter care than do men. They are also less likely to be seen regularly by an experienced physician, to be on antiretroviral therapy or to take medication to prevent opportunistic infections.[4] A review of the research on women and HIV/AIDS found that drug use, high-risk sex behaviors, depression and unmet social needs impede women's use of available HIV prevention and treatment services.[5]

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3. Ibid, p. 20.

4. U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau, "Women and HIV/AIDS," *HRSA Care Action*, December 1998.

5. Hader, S.L., Smith, D.K., Moore, J.S. and Holmberg, S. D., "HIV Infection in Women in the United States: Status at the Millennium," *Journal of the American Medical Association*, 2001; 285: 1186–1192.

C. Substance Abuse and Mental Health

Women at risk for HIV infection and substance abuse face a wide range of complex psychosocial and economic problems that place them at higher risk for HIV infection. Among these factors are a history of mental illness,[6] physical and sexual abuse, sexual assault and domestic violence.[7] Other contributing factors include having sexually transmitted diseases (STDs), multiple sex partners and drug-injecting sex partners; exchanging sex for money;[8] and experiencing incarceration,[9] poverty, and poor access to health care and prevention services.

Although much of the focus on the dual epidemics of HIV and substance abuse has centered on injecting drug use, the use and abuse of other substances—such as alcohol and crack—may place women at greater risk for HIV infection due to sexual transmission. Frequent and heavy alcohol consumption may impair a woman's judgement or place her at risk of abuse by others, thus increasing HIV risk. According to Wingood and DiClemente, women were less likely to use condoms if they consumed alcohol between 20 and 30 days of every month.[10] Women who use crack or cocaine may not be sharing injection drug equipment, but they are still at great risk for HIV through sexual exposure when they engage in unprotected sex with their primary partners or exchange sex for money or drugs. In one study, for example, 68 percent of women who were regular crack users had exchanged sex for drugs or money and 30 percent of them had not used a condom in the past 30 days.[11] The Women's Interagency HIV Study (WIHS) of the National Institutes of Health also found that crack, cocaine, or injecting drug use was associated with inconsistent condom use.

According to Fazzone, Holton and Reed, women who abuse alcohol and other drugs are more likely to become victims of domestic violence, and those who are victims of domestic violence are more likely to become dependent on alcohol and other drugs.[12] Wingood and DiClemente also found that women in abusive relationships were less likely to use condoms, putting themselves at risk for HIV infection. Furthermore HIV-infected women were at risk

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6. Amaro, H. and Hardy-Fanta, C., "Gender relations in addiction and recovery," *Journal of Psychoactive Drugs*, October-December 1995, 27(4): 325–337.

7. Fazzone, P., Holton, J. and Reed, B., *Substance Abuse Treatment and Domestic Violence, Treatment Improvement Protocol Series 25*, 1997, Substance Abuse and Mental Health Services Administration, Rockville, Maryland, p. 3.

8. Cotten-Oldenburg, N., Jordan, B., et.al, "Women inmates' risky sex and drug behaviors: Are they related?" *American Journal of Drug & Alcohol Abuse*, February 1999, 25(1): 129–49.

9. Schilling, R., el-Bassel, N., Ivanoff, A., et.al, "Sexual risk behavior of incarcerated, drug-using women," *Public Health Report*, July–August 1994, 109(4): 539–47.

10. Wingood, G. and DiClemente, R., "The influence of psychosocial factors, alcohol, drug use on African American women's high-risk sexual behavior," *American Journal of Prevention Medicine*, July 1998, 15(1): 54–59.

11. Edlin, B., Irwin, K., Faruque, S., et al, "Intersecting epidemics: Crack cocaine use and HIV infection among inner-city young adults," *New England Journal of Medicine*, 1994, 331: 1422–1427.

12. Fazzone, P.

for domestic violence when disclosing their status to their partners or spouses.[13]

Mental health problems, such as post-traumatic stress disorder (PTSD), may play a critical role in accounting for risky sexual behavior among women. Fifty-nine percent of women crack users in South Bronx were found to have PTSD due to traumas such as assault, rape, being a witness to murder, homelessness or loss of children.[14] Moreover, depression can have an adverse affect by making women less likely to value their own lives, less likely to avoid HIV infection, and more likely to engage in risky sexual behavior or substance abuse as a means to self-medicate.[15]

Psychological distress also impacts health care utilization among HIV-positive women as does the use of both injected and non-injected substances, which leads to lower utilization of health care.[16] In one study, 31 percent of women who tested positive for HIV delayed seeking care for three months or longer due to fear, depression and anxiety about their serostatus. Of 2,000 women enrolled in the WIHS, close to 50 percent reported a history of sexual abuse, and 60 percent had been victims of domestic violence.

According to the Office of Research on Women's Health (ORWH) of the National Institutes of Health, 12 percent of African American and 13 percent of Latina women reported sexual abuse as a child, compared to 11 percent of white women. As adults, African American women were more likely (16 percent) to report having experienced any form of spousal abuse than Latinas (10 percent) or white (8 percent) women. Although the reported incidence of rape per 1,000 females was higher for African American women (two per 1,000) than for Latinas (one per 1,000), a larger percentage of Latinas (4 percent) than African American women (2 percent) reported having been raped.[17]

D. Immigrant Status, Language and Literacy

Foreign-born women who are not citizens, including Latinas, face additional problems related to their immigrant status. Federal immigration and welfare reform policies have cut services for immigrants, whether documented or undocumented. These policies have also resulted in fear and mistrust of the health care system.[18] While the rates of HIV/AIDS among immigrant populations are not known, cultural and language barriers may place immigrants at greater risk of

13. Wingood, G. and DiClemente, R., "The effects of an abusive primary partner on the condom use and sexual negotiation practices of African American women," *American Journal of Public Health*, June 1997, 87(6): 1016–1018.

14. DeCarlo, P., Stall, R. and Fullilove, R., "What are substance abusers' HIV prevention needs?" *University of California San Francisco Center for AIDS Prevention Studies Fact Sheet: 1999.*

15. "Understanding Depression," *Perspectives*, 6(4), May 1997.

16. U.S. Department of Health and Human Services, p. 4.

17. Office of Research on Women's Health, Office of the Director, National Institutes of Health, *Women of Color Health Data Book: Adolescents to Seniors*, NIH Publication No. 98–4247, p. 60–61.

18. Rogers, D., *HIV Prevention and Education in the City of Boston*, Boston Public Health Commission, Boston, Massachusetts, 1998.

HIV infection due to lack of linguistically specific, accurate and culturally appropriate HIV information. Immigrants may also be at higher risk of HIV infection due to lower utilization of health care services, lack of insurance coverage and fears of possible deportation. Other factors such as lower educational attainment and literacy levels and strong cultural gender norms regarding sexuality may place immigrant women, particularly Latinas, at higher risk for HIV infection.[19]

E. Incarceration

In 1997 the AIDS case rate among incarcerated persons was 362 per 100,000 compared to 18 per 100,000 in the general population. Incarcerated women have higher rates of HIV infection than their male counterparts. In state prisons the incidence of HIV ranged from 12 to 26 percent among women compared to 8 to 21 percent among men. An increasing number of inmates are serving sentences for drug related offenses, which, according to the U.S. Department of Justice, has tripled the prison population in the last 18 years. Much of this increase occurred after 1993, when drug-sentencing laws changed to enforce stricter sentences on drug dealers and drug users. More than 50 percent of people incarcerated during this time period were charged with a drug-related offense. About 51–83 percent of the male and 41 to 84 percent of the female arrestees tested positive for drugs in 1995. Approximately 70 percent of people in prison in 1998 had a history of injection drug use or substance abuse.[20]

19. Gomez, C., et al., "Sex in the new world: An empowerment model for HIV prevention in Latina immigrant women," *Health Education and Behavior*, 26(2), April 1999, p. 200–212.

20. U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, "HIV and STDs in Correctional Facilities," February 1998.

IV. About SAMHSA

The mission of the Substance Abuse and Mental Health Services Administration (SAMHSA) within the nation's health system is to improve the quality and availability of prevention, early intervention, treatment and rehabilitation services for substance abuse and mental illnesses, including co-occurring disorders, in order to improve health and reduce illness, death, disability and cost to society.

SAMHSA's unique mission as an agency of the federal government is accomplished through national leadership and partnership with all concerned with substance abuse and mental illnesses in order to:

- Support prevention and early intervention and promote health.
- Develop, identify, evaluate, disseminate and promote effective policies and appropriate, high-quality services at the lowest realistic cost and with the best possible outcomes.
- Assure and improve access to needed services.
- Support recognition and understanding of the distinct characteristics and differing prevention and treatment needs of the illnesses and disorders that are encompassed by SAMHSA's mission.
- Support recognition that two or more of these conditions often co-occur in the same individual and that prevention and treatment service systems must provide for necessary coordination of services according to the needs of the individual.
- Eliminate stigma and discrimination.

These core national leadership functions are the basis for SAMHSA's programs and activities. In partnership with states and other entities, SAMHSA strives to address the needs of individuals with substance abuse and mental illnesses and community risk factors that contribute to these illnesses. Substance abuse activities are intended to reduce incidence and prevalence, improve access to prevention and treatment programs, enhance effectiveness of services, and reduce personal and community risks. Mental health activities are intended to promote recovery and improve the quality of life of adults with a serious mental illness and children with a serious emotional disturbance. Activities are also aimed at improving the overall mental health of the nation's people by promoting access to and increasing the development of systems of integrated, comprehensive, community-based services for adults with a serious mental illness and children with a serious emotional disturbance.

V. Project Summary

A. Purpose

The Substance Abuse and Mental Health Services Administration (SAMHSA) funded the National Minority AIDS Council (NMAC) to develop a policy document to address the numerous HIV, substance abuse, mental health and primary health care needs of African American and Latina women. This document also serves to guide future SAMHSA activities in the area of substance abuse and mental health targeting African American and Latina women. This report includes policy recommendations for knowledge development, technical assistance and collaborative activities sponsored by SAMHSA for the benefit of African American and Latina women at risk of HIV infection and those living with HIV/AIDS.

B. Policy Forum

To develop the document, NMAC in collaboration with SAMHSA conducted a policy development meeting, "Policy Forum on Coordination of HIV/AIDS, Substance Abuse and Mental Health Services for African American and Latina Women," on April 12–13, 1999, in Baltimore, Md. The purpose of the meeting was to identify barriers to effective programs for African American and Latina women and to develop strategies that address these. Working in collaboration with the SAMHSA associate administrator for HIV/AIDS, the meeting brought together approximately 60 researchers, service providers and consumers of services in the areas of substance abuse, mental health and HIV/AIDS services from various parts of the country. The participants were ethnically diverse and included a significant number of African American and Latino/a researchers, service providers and consumers.

The meeting format included plenary presentations on the issues related to African American and Latina women and coordination of HIV/AIDS, substance abuse and mental health services for them. Following the presentations, the large group was divided into four breakout groups that met for two half days to identify service needs and barriers to service, and to develop recommendations for SAMHSA to consider for its future knowledge, development and application (KDA) and technical assistance activities.

C. Focus Group

The preliminary barriers and recommendations from the Policy Forum were presented at two Focus Group Sessions held on June 29, 1999, during SAMHSA's Second National Conference on Women held in Los Angeles, Calif. The Focus Group was composed of 25 invited consumers and providers of substance abuse, mental health and HIV services from different regions of the country. The participants were ethnically diverse and included a significant number of African Americans and Latinos/as.

The Focus Group Sessions consisted of a presentation on the needs of incarcerated women and two panel presentations on the draft report and recommendations resulting from the Policy Forum. These Focus Group Sessions provided participants with the opportunity to review the draft document and provide additional input.

VI. Findings

A. Populations

The Policy Forum participants were asked to identify the subpopulations of women of color who face barriers to primary care, HIV prevention and services, substance abuse prevention and treatment and mental health services. While the participants recognized that many women of color face significant barriers to access these services, they indicated that the subpopulations listed below deserved particular attention since they have been historically subjected to discrimination and have been underserved by the health care system.

The Policy Forum participants decided to focus on the following subpopulations of women of color to identify barriers to services and to formulate recommendations for service coordination:

- Women over 50 years of age
- Substance abusers
- Transient populations and rural women (immigrant, migrant, homeless)
- Incarcerated women
- Women with high risk partners
- Adolescents
- Women with children

B. Barriers

The Policy Forum participants identified a range of barriers to service coordination for African American and Latina women. These barriers can be grouped into the following three general categories:

- **Structural:** many programs have been designed without taking the specific needs of women of color into consideration. The structure and design of many programs are therefore unresponsive to the complex psycho-social and cultural needs of women of color.
- **Categorical Funding:** available funding is distributed by different governmental agencies for specific activities and services. Categorical funding requirements limit the ability of service providers to offer the full array of services that women need. Such funding requirements contribute to fragmentation of services and thus force women to travel to multiple sites/programs to address their multiple needs.
- **Systemic:** due to the lack of women focused services and the fragmentation of the service delivery system, women must attempt to piece together their own network of service providers. The current funding and service delivery arrangements provide little or no incentives for the providers themselves to coordinate and link with each other to deliver a continuum of comprehensive services to women of color.

1. Structural Issues

Health Insurance: African Americans and Latinos/as have higher rates of uninsured and underinsured individuals when compared to whites. Lack of adequate insurance coverage limits the accessibility and availability of quality preventive, primary health care and treatment services. This lack of insurance is generally related to unstable

employment or temporary, seasonal, migrant or minimum wage work. Lack of health insurance is one reason why there are racial and ethnic disparities in health care and gaps in health outcomes for African Americans and Latinos/as when compared to whites.

Racism and Discrimination: African American and Latina women have experienced racism and discrimination in obtaining and retaining adequate health care, substance abuse and mental health services. The needs of African American and Latina women have been marginalized and given low priority in the decision-making processes that determine which services will be offered and the level of funding available to support such services.

Cultural Competency, Sensitivity, and Culturally-Specific Services: Program effectiveness is limited and health outcomes reduced when all services are not culturally appropriate and the staff delivering the services is not culturally competent. Service providers do not always have the knowledge and skills to respond to the social context in which women of color live their lives and to address the cultural norms, values, beliefs and attitudes that impact on their health-seeking behaviors. To be effective, health care, substance abuse and mental health services must be culturally competent and offered to women of color within the context of their culture and life situations.

Confidentiality: Disclosure of HIV status may have negative consequences for women, including violence, stigma and discrimination and—in the case of immigrant women—may lead to deportation. Fear of disclosure and lack of confidentiality may deter women from seeking services. Programs do not always ensure client confidentiality or make women feel comfortable enough to seek HIV testing and obtain services.

Competing Priorities: Many health care, substance abuse and mental health services offered to women of color do not address the competing priorities they experience, including economic subsistence; employment; housing; transportation; family responsibilities; parenting and child-care; and care-giving for children, partners, spouses and parents.

Terminology: The terms used in describing the components of effective service delivery and their implications for the design and delivery of services to African American and Latina women have not been clearly defined. Many service providers have various interpretations of these terms and therefore implement these service components differently.

2. Categorical Funding Issues

Program Design: Due to categorical funding requirements, many programs available for women are designed to address one health or service area, and few programs provide the full range of services that women need. Many service providers have difficulty developing and implementing comprehensive services for women because the various funding streams have different program standards, guidelines, and fiscal and grant management requirements. This leads to fragmentation of services.

Cross Training: There is a lack of knowledge and understanding across mental health, substance abuse and HIV/AIDS service disciplines. Most practitioners are proficient and skilled in their individual service areas and disciplines. Training across disciplines and fields of practice is critical given the complexity of problems and needs of women of color with the co-occurring conditions of substance abuse, mental health problems and HIV/AIDS. Coordination of cross training is therefore a high priority in order to improve coordination of services for this population.

Intra-System Collaboration: Service providers are unwilling or unable to coordinate delivery of coordinated health care, treatment and ancillary services due to:

- Size and complexity of the service delivery systems and lack of knowledge about existing federal, state and local programs
- Turf issues and competition for funding
- Lack of incentives and information to facilitate collaboration
- Lack of communication and interaction between community-based programs and federal agencies
- Agencies' reluctance or failure to fund programs that do not fit into the traditional way that business is done
- Limited time in the grant application process for the development of interagency agreements
- Lack of continuity of funding and funding cycles
- Funding agencies' inability to effectively and expeditiously disseminate research findings to providers for application to their program designs

3. Systemic Issues

Service Fragmentation: Due to categorical funding requirements most HIV, substance abuse and mental health services for women are offered within a fragmented system. Women of color with complex and multiple problems are often forced to seek HIV/AIDS prevention and care, substance abuse, mental health and other ancillary services from different service delivery sites and agencies that may have different application and eligibility criteria. Fragmentation within the service delivery system therefore increases the barriers to access for women of color. Lack of transportation and need for childcare exacerbates this problem.

Governmental Accountability and Commitment: Governmental agencies have not demonstrated a commitment to provide comprehensive services for African American and Latina women. Participants cited a number of instances where findings and recommendations from various policy projects were put together yet were not acted upon by governmental agencies.

VII. Recommendations by Issue Area

The recommendations presented below are based on those made during the April 1999 Policy Forum and the feedback obtained in June 1999 during the Focus Group Sessions.

A. Client-Centered Programming

Program Design: SAMHSA must promote and ensure the implementation of client-centered and client-driven programs so that providers can understand the clients they serve and develop programs that respond to the clients' values, beliefs and decision-making processes. Prevention, treatment and care programs must provide age-appropriate, family-focused services that address the needs of women of color of various backgrounds and age groups. Among the issues that need to be addressed in this context are:

- Phase of HIV disease progression
- Developmental stage
- Empowerment and the enhancement of self-esteem through education, skills building and self-care
- The interrelationship of poverty and health status
- Community-based health service models
- Competing priorities
- The role of grandparents as caregivers
- HIV testing policies and disclosure of HIV status
- Language and cultural competence, accounting for cultural differences in behaviors and coping responses
- Inpatient, outpatient and drop-in centers
- Integration of substance abuse and mental health services delivered within a continuum of care
- Transportation and child care
- Education about sexuality and risk factors for HIV, including STDs, substance abuse and partner risk factors
- Pre-release service planning and coordination for incarcerated women and partners of incarcerated men
- HIV prevention programs for heterosexual men

Funding: SAMHSA should provide funding for the development of service delivery models that integrate HIV/AIDS, substance abuse and mental health services. SAMHSA should also provide funding to support capacity building, evaluation and monitoring activities for non-profit organizations providing integrated services. SAMHSA and other HHS Operating Divisions should work with national organizations to improve the capacity of directly-funded community-based organizations in accessing state and local funding to enhance continuity of services.

State-level funding: SAMHSA should include language in the Substance Abuse Prevention and Treatment (SAPT) and Community Mental Health Services (CMHS) Block Grant regulations to require states to provide funding to successful demonstration programs for women once the direct funding has ended.

B. HIV-Related Planning, Priority-Setting and Funding Allocations

Client Participation: SAMHSA should encourage state and local government agencies to increase participation of consumers in the planning processes for priority setting and funding allocations for HIV/AIDS, substance abuse and mental health services. SAMHSA's program guidance should encourage leadership development for women and others living with HIV/AIDS and promote their participation in the development of program plans, policies and funding initiatives. African American, Latina and other women of color affected by HIV/AIDS should be represented in significant numbers on these planning bodies. The leadership of persons living with HIV/AIDS should be encouraged and supported at all levels including government, non-profit and community-based organizations.

Treatment and Service Providers: SAMHSA should develop strategies to increase the participation of drug treatment providers and agency representatives in HIV-related planning bodies. This may be done as part of technical assistance initiatives in partnership with Health Resources and Services Administration (HRSA) and CDC.

Interagency Collaboration: SAMHSA should work with state HIV/AIDS directors and substance abuse and mental health Single State Agency (SSA) directors to increase interagency activities.

Regional Advisory Bodies: SAMHSA should establish regional advisory bodies to obtain input on the needs of women of color related to HIV, substance abuse and mental health. These advisory committees should reflect the demographics of the local epidemic and include consumers of mental health, HIV and substance abuse services; persons in recovery; and service providers.

C. Systems Coordination, Collaboration and Services Integration

Program Design: SAMHSA, in collaboration with HRSA and CDC, should encourage the development and implementation of "one-stop shopping" service delivery models, providing various co-located services in one service site, aimed at increasing access to care for women with HIV/AIDS and co-occurring substance abuse and mental health conditions.

Community-based Research: SAMHSA, in collaboration with the National Institute on Drug Abuse (NIDA), should develop initiatives to promote collaboration between community-based service providers and research institutions, especially on issues related to African American and Latina women. These projects should be aimed at building research capacity within community-based organizations.

Funding: Federal and state funding agencies should support projects that promote interagency coordination and collaboration and provide integrated HIV/AIDS, substance abuse and mental health services for women. These agencies' funding review criteria should give greater weight to service integration.

Training: SAMHSA should provide training and materials for state health, education and justice departments; substance abuse and mental health SSAs; and HIV/AIDS programs in the areas of interagency collaboration, coordination and integration of services. Among the materials that can be provided are: Treatment Improvement Protocols (TIPs), Technical Assistance Publications (TAPs) and Prevention Enhancement Protocols (PEPs).

Guidance: SAMHSA's Guidance for applicants (GFAs) should include language requiring inclusion of the HIV-related priorities set by SSAs for substance abuse and mental health, Ryan White CARE Act HIV Planning Councils and Consortia and the CDC HIV prevention community planning groups. The GFAs should also encourage the use of shared or pooled funding streams.

D. Federal Agency Coordination

Interagency Collaboration and Coordination: The Secretary of the Department of Health and Human Services (HHS) should encourage HRSA, CDC, SAMHSA and other HHS agencies to interact more closely with each other and collaborate on HIV-related programs and services. HHS agencies should report back to the Secretary on a quarterly or semi-annual basis on their coordination and collaboration efforts, and the development of mechanisms at the departmental level to share goals and plans and to explore opportunities for joint funding of integrated services. SAMHSA, CDC, HRSA and the National Institutes of Health (NIH) should co-sponsor a conference focusing on strategies to enhance cross systems collaboration and the integration of women-centered HIV, substance abuse, and mental health services. The conference, should be geared to the staff of the various federal agencies and state level administrators, and should provide information and strategies, models that work, and best practices. SAMHSA should also develop materials to encourage interagency collaboration.

Funding: HHS should increase funding to operating divisions to engage in cross-agency funding initiatives to support programs that provide one-stop shopping service models for women with co-occurring HIV, substance abuse and mental health disorders.

Cross Training: SAMHSA should carry out training for federal staff in policy-making, priority setting, funding allocations and joint funding. In addition, SAMHSA should conduct a training aimed at state and local staff and service providers on coordination of services for women and strategies to engage in successful collaboration.

E. Program Accountability

Evaluation: Federal, state and local agencies must demonstrate that funding is being used to provide integrated services for women. SAMHSA must closely monitor the SAPT and CMHS Block Grants and other funding that goes to the states and local organizations to ensure that integrated services are made available to women.

Technical Assistance: SAMHSA should develop initiatives for historically black colleges and universities and Hispanic-serving institutions to provide technical assistance

and support to community-based service providers on program evaluation. These initiatives should be aimed at strengthening the capacity of community-based providers to effectively integrate evaluation into their program design and implementation.

Research and Evaluation: SAMHSA should disseminate research and evaluation findings to the states, local governments and community-based providers. In addition, SAMHSA should fund hands-on training and technical assistance to community-based providers on the integration of research and evaluation findings into the design, development and delivery of their program services.

VIII. Recommendations by Population

A. Women and Children

SAMHSA should collaborate with HRSA to integrate mental health and substance abuse services to Ryan White CARE Act services, especially those funded under the Title IV programs for women, children and youth.

SAMHSA should collaborate with HRSA and CDC to provide cross training to community-based organizations they fund, focusing on the integration of HIV, substance abuse, mental health, prevention, treatment, primary health care and supportive services for African American and Latina women.

B. Adolescents

SAMHSA should promote the development of integrated service delivery models to address the specific needs of adolescents, including the special development needs of African American and Latina/Hispanic adolescent females.

C. Women Over 50

SAMHSA should collaborate with CDC and HRSA to convene an interagency meeting on approaches to meet the HIV-related needs of women over 50 and to promote dissemination of HIV prevention information targeting them. The three agencies should sponsor joint media and marketing campaigns aimed at women over 50 impacted by HIV/AIDS. HRSA-funded AIDS Education and Training Centers and the SAMHSA-funded Addiction Technology Transfer Centers and Centers for the Application of Prevention Technologies should develop materials and training workshops.

SAMHSA and other federal agencies should collaborate with national advocacy organizations, such as the American Association for Retired Persons (AARP), and Latino and African American organizations to promote advocacy for services to meet the HIV, substance abuse and mental health needs of women over 50. The initiatives must be culturally appropriate and aim to address prevention and service needs. Materials for this population should be made available in English, Spanish and other languages spoken by this population.

SAMHSA should collaborate with national minority organizations and other national organizations that advocate for older persons to convene a meeting to explore effective media and educational strategies to reach women of color over 50. Representatives from churches, retirement communities and senior citizens programs should be invited to attend.

D. Rural, Immigrant and Migrant Populations

HHS should collaborate with the State Department to provide funding for community partnership grants to address substance abuse, mental health and HIV-related needs of immigrants across international borders with Mexico and Caribbean countries.

CDC, HRSA, and SAMHSA should develop collaborative efforts to coordinate services for migrant women and their families in the areas of health care, HIV/AIDS, substance abuse and mental health services through expansion of service in community and migrant health centers and other programs serving rural and migrant communities.

SAMHSA, HRSA and other federal agencies should use successful service initiatives, such as the border health initiative model, to address the primary health care and HIV/AIDS, substance abuse and mental health service needs of border and migrant populations. Some of these programs use "promotoras" (health workers) and other culturally appropriate interventions to increase access to care and prevent HIV-risk behavior. These models should be replicated in other areas, and funded organizations should be supported with additional federal funding through interagency collaboration.

SAMHSA, CDC and HRSA should develop collaborative efforts through joint funding initiatives to increase access to integrated substance abuse, mental health and HIV prevention and treatment services to women living in rural and isolated areas. Innovative strategies such as the cross training of community-level providers and educators and the provision of technical advice and support via teleconferencing and the Internet should be explored.

E. Incarcerated Women

Federal, state and local correctional facilities should make drug treatment and HIV/AIDS prevention and care services available for incarcerated women. SAMHSA should promote collaborative efforts that include federal, state and local corrections staff in planning for the HIV/AIDS, substance abuse and mental health services for incarcerated women.

SAMHSA should collaborate with the Office of National Drug Control Policy (ONDCP) and with the Department of Justice (DOJ) to develop initiatives for drug treatment services within correctional facilities. In addition, HIV and STD prevention and education programs should be provided to incarcerated women, including sex workers. SAMHSA should also work in collaboration with the Department of Education and the Department of Labor (DOL) to provide educational, skills training and job placement services to incarcerated women.

SAMHSA should collaborate with other federal agencies including ONDCP, DOJ and NIDA on the development and implementation of programs for incarcerated women impacted by HIV/AIDS, stressing models that provide integrated HIV, substance abuse and mental health services.

HHS should encourage interdepartmental collaborative efforts with the Department of Housing and Urban Development (HUD), DOJ and DOL aimed at recently incarcerated women, including funding to address HIV/AIDS, mental health and substance abuse services, especially among sex workers.

F. Substance Using and Abusing Women

SAMHSA should collaborate with CDC, NIDA, HRSA and other federal agencies to develop HIV and substance abuse prevention and treatment and mental health services tailored to women and adolescents addicted to crack cocaine.

SAMHSA should increase resources for targeted capacity expansion initiatives providing women-focused programs aimed at African American and Latina adolescents, pregnant women, and women and their children. Funded residential drug treatment programs must be comprehensive and culturally competent and must provide HIV prevention and treatment, primary health care, mental health and support services on site or through linkages with other providers.

SAMHSA should fund projects to demonstrate the effectiveness of treatment readiness and harm-reduction strategies targeting women who are not ready or unable to enter treatment and are at risk for or living with HIV.

IX. General Recommendations

SAMHSA should enhance mechanisms to communicate with community organizations so they can obtain information on available federal and state funding and how to apply. Information should be disseminated through the Internet, e-mail, mail and telephone.

Individuals whose travel to conferences is federally sponsored should report back to their agencies and other community organizations on conference contents to provide updates on best practices and programs.

SAMHSA advisory board members should share information on meetings and conferences with local communities.

SAMHSA should provide periodic updates on implementation of the recommendations in this report.

The Center for Mental Health Services (CMHS) needs to develop additional programs to address the HIV, mental health, co-occurring conditions and chronic mental health issues of women in general and women of color in particular.

SAMHSA should provide funding for the development, implementation and evaluation of cross-training and cross-systems collaboration at the local level and for the development of interagency work plans.

SAMHSA should collaborate with national and local organizations to provide training on policy advocacy for substance abuse, mental health, and HIV service providers and consumers on the impact of welfare reform, child welfare, Medicaid and managed care on the delivery of integrated cross-trained services for African American and Latina women.

SAMHSA should evaluate the substance abuse and mental health services targeting women in Puerto Rico and the Virgin Islands to determine if these jurisdictions should receive targeted capacity expansion funding. SAMHSA should target resources and provide cross training for service providers on integrated HIV, substance abuse and mental health services for women in Puerto Rico and the Virgin Islands.

SAMHSA should provide support for additional meetings focusing on women of color with co-occurring conditions that bring together researchers, service providers, consumers of services and federal and state officials.

X. Acknowledgements

This Policy Research Project was carried out with the support and contributions of many subject area experts, researchers, service providers, consumers of services, and state and federal officials. These experts participated in the Policy Forum held in Baltimore, Md., in April 1999, and the Focus Group Session held in Los Angeles, Calif., in June 1999. The Substance Abuse and Mental Health Services Administration funded the National Minority AIDS Council to develop this policy document. Miguelina León, director of Government Relations and Public Policy for NMAC worked in collaboration with M. Valerie Mills, Ph.D., M.S.W., SAMHSA's associate administrator for HIV/AIDS, to develop and carry out this policy research project. Dr. Mills, provided the leadership, vision and support for the project; The assistance of the following persons was also critical to the success of this project:

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Deya Smith, legislative associate, NMAC, who provided assistance in coordinating the meeting logistics and facilitating the break out sessions; and

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Finally, a special note of thanks is given to the moderators and presenters who shared their knowledge, expertise and perspectives during the Policy Forum and Focus Group Session. A list of their names and affiliations is also provided in the appendices of this document.

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XII. Appendices

A. Policy Forum on Coordination of HIV/AIDS, Substance Abuse and Mental Health Services for African American and Latina Women

April 12–13, 1999
Baltimore, Maryland

AGENDA

Monday, April 12, 1999

7:30–9:00 am	**Registration & Continental Breakfast** *Harbor I, Foyer*
9:00–9:15 am	**Welcome and Introductions** *Harbor I* Dr. M. Valerie Mills Associate Administrator for HIV/AIDS, SAMHSA Miguelina León Director of Government Relations and Public Policy, NMAC
9:15–10:45 am	**Opening Plenary** *Harbor I* Moderator: Warren Hewitt Director AIDS Programs Center for Substance Abuse Treatment, SAMHSA **Overview: HIV/AIDS, Substance Abuse and Mental Health Trends Among African American and Latina Women** Dr. Lucille C. Norville Perez Associate Director, Office of Medical & Clinical Services SAMHSA/CSAP **Overview: Research Findings on African American & Latina Women Affected by HIV/AIDS** Dr. Cynthia Gómez Assistant Adjunct Professor, Department of Medicine, UCSF, Center for AIDS Prevention Studies **Summary of NIH Research: The Interface between HIV/AIDS, Substance Abuse and Mental Health Issues** Dr. Judith Auerbach Chair, Behavioral & Social Sciences Research Coordinating Committee, Office of AIDS Research, NIH **Challenges & Barriers to Services Coordination for Women with Multiple Needs** Sandra McDonald President/Founder, Outreach, Inc.

Monday, April 12, 1999, continued

9:15–10:45 am	**Opening Plenary, *continued*** *Harbor I* **Perspectives of Woman Living with AIDS** Karen Mc Manus Executive Director, Women of Color AIDS Council Questions and Answers
10:45–11:00 am	**Break**
11:00–11:15 am	**Charge to the Group – Breakout Group Instructions** *Harbor I* Jacqueline Coleman Director of Technical Assistance, NMAC
11:15–12:00 Noon	**Break Out Groups Convene: Identify Service Needs and Gaps**

Green *Harbor I*	**Red** *Harbor IIB*
Yellow *Harbor IIA*	**Blue** *Mc Henry II*

12:00–1:00 pm	**Lunch** *Camden View*
1:15–3:15 pm	**Breakout Groups Reconvene: Identify Barriers to Coordination & Prioritize Issues to be Addressed**
3:15–3:30 pm	**Break**
3:30–4:30 pm	**Breakout Groups Report Out to Large Group** *Harbor I*
4:30 pm	**Adjourn**

Tuesday, April 13, 1999

7:30–8:30 am	**Registration & Continental Breakfast** *Harbor I, Foyer*
8:30–9:15 am	**Welcome and Recapitulation of Day I** *Harbor I* Dr. M. Valerie Mills Associate Administrator for HIV/AIDS, SAMHSA Miguelina León Director of Government Relations and Public Policy, NMAC
9:15–10:45 am	**Plenary: Innovative Strategies and Best Practices** *Harbor I* Moderator: Dr. Lawrence Brown Senior Vice President, Division of Medical Services, Addiction Research and Treatment Corporation, Inc. **Elements of Best Practices in Services Coordination** Derya Williams Associate Executive Director, River Region Human Services **Innovative Service Models** Dr. Vivian Brown Chief Executive Officer PROTOTYPES

Tuesday, April 13, 1999, continued

9:15–10:45 am	**Plenary, continued** *Harbor I* **State Level Coordination Efforts** Dr. Liza Solomon Director AIDS Administration, Maryland **Challenges Facing Rural and Border Areas** Rebeca Ramos Director, Division of Training and Technical Assistance, U.S.–Mexico Border Health Association **State Level Strategies** Philip McCullough, Director, Wisconsin, DHFS, Bureau of Substance Abuse Services **Reflections and Recommendations** Belynda Dunn African American Education Program Manager, AIDS Action Committee of Boston GiGi Nicks Patient Advocacy Director, CORE Center, Cook County Hospital **Perspectives of Woman Living with AIDS** Vivian Torres Educator, Community Access Questions and Answers
10:45–11:00 am	**Charge to Participants** *Harbor I* Dr. Nelba Chavez Administrator, Substance Abuse and Mental Health Services Administration
11:00–11:15 am	**Break**
11:15–12:00 Noon	**Break Out Groups Convene: Develop Strategies to Address Barriers/ Gaps and to Improve Coordination** **Green** *Harbor I* **Yellow** *Harbor IIA* **Red** *Harbor IIB* **Blue** *Mc Henry II*
12:00–1:00 pm	**Lunch** *Camden View* **Overview of SAMHSA's Programs and Budget** Judith Braslow Deputy Associate Administrator, Program, Policy Coordinator, SAMHSA
1:15–3:00 pm	**Breakout Groups Reconvene: Prioritize Recommendations**
3:00–3:15 pm	**Break**
3:15–4:00 pm	**Breakout Groups Report Out to Large Group** *Harbor I*
4:15–4:30 pm	**Wrap Up and Next Steps** *Harbor I* Miguelina León, NMAC Dr. M. Valerie Mills, SAMHSA

B. Breakout Group Facilitators

Green Group

Martha Duncan Bond, Deputy Director, SAMHSA/CSAP Office of Medical and Clinical Affairs

Mr. Carlos Vélez, Executive Vice President, Vélez Associates

Yellow Group

Ms. Jacqueline Coleman, Director of Technical Assistance, NMAC

Mr. Stephen Trujillo, Director, Quality Management, CODAC Behavioral Health Services, Inc.

Red Group

Mr. Robert Baxter, Supervising Community Service Officer, New Jersey Department of Health

Ms. Sylvia Edwards, Consultant

Blue Group

Ms. Karen Braxton, Contractor, CRP, Inc.

Ms. Deya Smith, Legislative Associate, NMAC

C. Break Out Group Assignments: Policy Forum April 12–13, 1999

Green *Harbor I*

Facilitators:

Ms. Martha Bond
Mr. Carlos Velez

Participants:

Rev. Cheryl Anthony
Dr. Vivian Brown
Ms. Martha Castañeda
Ms. Angela Fulwood
Mr. Warren Hewitt
Ms. Yevette Lindsey
Mr. Philip Mc Cullough
Ms. GiGi Nicks
Ms. Brenda Page Smith
Ms. Gail Sargeant
Ms. Julie Scolfield
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Yellow *Harbor IIA*

Facilitators:

Mr. Stephen Trujillo
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Participants:

Dr. Judith Auerbach
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Ms. Eugenia Foster-Adams
Ms. Beri Hull
Ms. Gloria Lockett
Ms. Beth Meyerson
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Ms. Rebeca Ramos
Rev. Pernessa Seele
Ms. Barbara Smith
Ms. Melissa Thomas Proctor
Ms. Sandra Vining

Red *Harbor IIB*

Facilitators:

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Ms. Charlene-Doria Ortiz
Ms. Carmen Rosa Diez
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Ms. Kayla Jackson
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Ms. Karen McManus
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Blue *Mc Henry II*

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Ms Abigail Martinez
Ms. Sandra Mc Donald
Ms. Francess E. Page
Ms. Ulonda Shamwell
Dr. Barbara Silver
Ms. Anna Wyman
Ms. Derya Williams

D. Breakout Group Instructions, Monday, April 12, 1999

Choose a reporter(s) for your group.

Select at least three (3) sub-populations of African American and Latina/Hispanic women that your group would like to address (see worksheet).

Identify the constellation of services in the delivery system that serve to draw African American and Latina/Hispanic women at risk of or living with HIV/AIDS to:

- HIV and substance abuse prevention services
- HIV, substance abuse treatment and mental health services

Identify the barriers which African American and Latina/Hispanic women at risk of or living with HIV/AIDS currently experience in accessing a continuum of HIV/AIDS, substance abuse prevention and care and mental health services.

Discuss individual, family and community, social and economic, and program and policy factors that contribute to the barriers to access. Include the following in your discussion:

- The role of mental health services in improving utilization of substance abuse, and HIV/AIDS prevention and treatment services (including HIV treatment adherence).
- The role of substance abuse treatment modalities (methadone maintenance, detoxification, residential, etc.) in HIV prevention.
- Culturally competent, bilingual, treatment readiness, gender specific, family centered bereavement and support services.
- The role of trauma, including sexual abuse, domestic violence and physical abuse, as a barrier to access.
- The role of stigma and discrimination as a barrier to access.

Discuss how these factors and the barriers to services are being addressed through research, program planning, funding and policy.

Prioritize the constellation of services, which are most critical to addressing the needs of African American, and Latina/Hispanic women at risk of or living with HIV/AIDS.

E. Breakout Group Instructions, Tuesday, April 13, 1999

Choose a reporter(s) for your group.

Select at least three (3) sub-populations of African American and Latina/Hispanic women that your group would like to address (see worksheet).

Based on the first day's discussion:

Select the constellation of HIV/AIDS substance abuse and mental health services needed by each of the sub-populations your group is addressing.

Discuss the factors, which affect coordination of these services among service delivery systems at the following levels:

- State, regional, local, community
- Policy, program, funding, and staff levels

Identify strategies which will improve and enhance coordination of services among substance abuse, mental health and HIV/AIDS service providers to respond to the needs of the sub-populations selected.

Develop and prioritize at least (4) recommendations for SAMHSA's future "Knowledge, Development and Application" and training and technical assistance activities, which will serve to address the barriers to coordination and improve services for African American and Latina/Hispanic women.

Substance Abuse and Mental Health Services Administration

NATIONAL MINORITY AIDS COUNCIL

Policy Forum on Coordination of HIV/AIDS, Substance Abuse & Mental Health Services for African American & Latina Women

April 12–13, 1999

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Substance Abuse and Mental Health Services Administration

NATIONAL MINORITY AIDS COUNCIL

Policy Forum on Coordination of HIV/AIDS, Substance Abuse & Mental Health Services for African American & Latina Women

Focus Group Sessions

AGENDA

Tuesday June 29, 1999

11:00–11:10 am	**Registration**
11:10–11:25 am	**Welcome and Introductions** Dr. M. Valerie Mills Associate Administrator for HIV/AIDS, SAMHSA
11:25–11:40 am	**Overview of the Project** Miguelina León Director of Government Relations and Public Policy, NMAC
11:40 am–12:00 pm	**Incarcerated Women and HIV/AIDS** Dr. Craig Love Research Associate, Brown University
12:00–12:15 pm	**Overview: Barriers to Services for African American & Latina Women Affected by HIV/AIDS** Anna Wyman Family Associate, University of Miami, Pediatrics Department
12:15–12:30 pm	**Feedback From Group and Discussion** Miguelina León Director of Government Relations and Public Policy, NMAC
12:30 pm	**Draft of SAMHSA Factsheets** Birch and Davis
4:15–4:30 pm	**Barriers to Coordination of HIV/AIDS, Substance Abuse & Mental Health Services for African American & Latina Women** Rev. Cheryl Anthony Pastor, Judah International Christian Center
4:30–5:00 pm	**Feedback from Group and Discussion** Miguelina León Director of Government Relations and Public Policy, NMAC
5:00–5:15 pm	**Strategies to Improve Coordination of HIV/AIDS, Substance Abuse & Mental Health Services for African American & Latina Women** Alma Candelas Director of Services for Special Populations, New York State Department of Health, AIDS Institute

Tuesday June 29, 1999, continued

5:15–5:35 pm	**Feedback from Group and Discussion** Miguelina León Director of Government Relations and Public Policy, NMAC
5:35–5:45 pm	**Feedback on Draft of SAMHSA Factsheets** Birch and Davis
	Adjourn

Substance Abuse and Mental Health Services Administration

NATIONAL MINORITY AIDS COUNCIL

Policy Forum on Coordination of HIV/AIDS, Substance Abuse & Mental Health Services for African American & Latina Women

June 29, 1999

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